Alaska Health Care Commission

COMMISSION MEETING NOTES

June 19-20, 2014 Meeting

MEETING SUMMARY: OUTCOMES AND NEXT STEPS

TRANSPARENCY

Following is a brief summary of the outcomes of a lengthy discussion on next steps for facilitating current Commission recommendations related to health care price and quality transparency.

- Recommendation #1 — Recommending implementation of a legislative mechanism for providing the public with information on health care prices and quality. The Commission considered the question: Should the Commission provide more detailed guidance for the Governor and legislature on potential provider transparency legislation?
  - The Commission briefly reviewed general information on other states' transparency laws, discussed issues and concerns, and determined they need:
    - Clarification on the Commission's transparency problem statements and goal statements
    - More information on what other states are achieving through transparency laws

- Recommendation #2 — Recommending the State mandate participation in the Hospital Discharge Database. The Commission received a status report on new Department of Health & Social Services (DHSS) regulations that implement this recommendation, and will continue to track implementation over time to determine whether it is achieving the intended outcome.

- Recommendation #3 — Recommending the State develop an All-Payer Claims Database (APCD). The Commission was provided the latest draft of the staff paper on key elements for state APCD legislation, but did not discuss it directly during the meeting.
  - The Commission determined they first want:
    - Clarification on the Commission's problem statements and goal statements relevant to the APCD recommendation
    - More information on what states with APCDs are doing and achieving with the data.

- Next Steps:
  - Stakeholder Session On Hold: The Commission determined it would be premature to plan a stakeholder session on transparency at this time.
  - Compile and review prior year Findings Statements approved by the Commission supporting the current transparency and APCD recommendations, and other background information.
  - Include a Transparency learning session on the Commission's draft 2015 agenda

LEGISLATIVE SESSION REVIEW

The Commission reviewed a list of health-related bills introduced in the 28th Legislature (2013-2014), categorized by the Commission's eight Core Strategies (available on the Commission's website). Mike Monagle, Director of the Division of Workers' Compensation, discussed legislation that aligned with Workers' Compensation Board recommendations for improving medical services quality and costs.

INSURANCE MARKET REGULATION

Concern that consumer protections codified a decade or more ago in insurance rules and laws may be outdated and create barriers to innovation and free market function was noted. The Commission will continue conversation on this topic with the Director of the Division of Insurance later in the year.

EMPLOYER SURVEY RESULTS

Dr. Guettabi of the Institute for Social & Economic Research presented highlights of the results of the Commission's contracted survey of Alaskan employers on health benefit practices. The final report will be published in July. Highlights of the presentation included:

- Percentage of Alaskan firms (of all sizes) offering health benefits to employees declined from 39% in 2006 to 34% in 2013.
- 29% of very small firms (<10 FTEs) offer employee health benefit, compared to 91% of large firms (>99 FTEs)
- The predominant reason for not offering health benefits cited by firms of all sizes (of those not offering benefits) was price and an inability to afford the expense.
- 19% of firms offer Health Reimbursement Accounts and 27% offer Health Flexible Spending Accounts to their full time employees.
- 50% of Alaskan firms think wellness programs are important or very important; but only 8% of firms have implemented a wellness program.

Follow-up questions the Commission has for Alaskan employers include:

- Are you moving away from more traditional, comprehensive plans to High Deductible Health Plans and other new plan designs?
- Are there other alternative ways you are looking at providing medical care for employees?
- How are health care costs in Alaska impacting your non-health care –related business decisions?

INSURANCE COVERAGE QUESTIONS

Beyond the new information on employer-sponsored insurance in Alaska gained through the survey, the Commission identified a need for future learning about:

- How insurance status affects access to health care in Alaska
- The difference between insurance coverage and other forms of health benefits (e.g., Military, VA, Indian Health Services)
- The current sources of coverage for Alaskans
- The demographics, especially by age, of the insured and uninsured populations
- How insurance plan design in Alaska compares to insurance plans in other states

FRAUD & ABUSE

Following-up on presentations on the Medicaid Integrity and Medicaid Fraud Control Programs at the March meeting, at this meeting the Commission had a presentation on Aetna's fraud control program and then discussed ideas for potential fraud and abuse control improvements for the Medicaid program. The Commission also learned about new and expanding medical claims management tools and initiatives aimed at reducing waste.

- Ideas discussed for potential Medicaid fraud control improvement recommendations included:
  - Enrollment of all rendering provider types
  - Targeting state audits to provider types that pose the greatest risk of fraud and abuse

- Reduction of administrative burden and cycle time of audit process, and improvement in communication with providers
- Provision of Explanation of Benefits statements to Medicaid recipients
- Request of the U.S. DHHS for a waiver from the Medicaid Recovery Audit Contractor program requirement
- Require bonding for Medicaid providers and strengthen state forfeiture laws to increase recovery of Medicaid funds lost to fraud
- Removal of statutory barriers to Alaska DHSS and Department of Law access to and use of the Prescription Drug Database

UPDATES

- Commissioner Streur (DHSS) met with the Commission and discussed the status of Affordable Care Act Implementation and also the Alaska Medicaid Reform Advisory Group, which is meeting monthly and will produce a report detailing Medicaid Reform ideas for the Governor in November.
- Healthy Alaskans 2020 leaders reported that the initiative has moved past the key indicator identification phase and is in the strategy development phase. An assessment of Alaska's public health system capacity was recently complete, and the report will be released in September. A significant challenge going forward is the loss of the federal grant supporting the initiative.

WRAP-UP

- Future 2014 Commission meeting planning:
  - Do not plan a stakeholder session on Transparency for the fall
  - Ideas for October Clinical Quality Improvement learning session include Virginia Mason's experience with Toyota Total Quality Management, Southcentral Foundation's clinical quality improvement initiative, consultation with the Institute for Healthcare Improvement, and a request to ASHNHA to identify Alaska hospital quality initiatives.
  - Members were asked to submit questions for August meeting presenters on behavioral health, rural sanitation, and Alaska's military/VA health systems to Deb over e-mail.
- Meeting evaluation: Change back to 1.5 day meeting length; and be more directive in facilitation.

MEETING FOLLOW-UP — NEXT STEPS:

I. Deb:
  - Provide Commission Members with links to:
    - Dr. Dobson's webinar on N. Carolina's Patient-Centered Medical Home program
    - Harold Miller's Payment Reform webinar
    - Healthy Alaskans 2020 Leading Health Indicators baseline/trend data report
    - HFMA's Consumer Guide to Understanding Health Care Pricing, and HFMA's Best Practices for Providers for Explaining Healthcare Prices to Patients
  - Draft Fraud & Abuse Finding & Recommendation statements based on points discussed in March and June meetings for Commission review and feedback.
  - Compile prior-year Finding statements related to Transparency and All-Payer Claims Databases for Commission review; and include future learning session on Transparency on draft 2015 Commission Agenda.
  - Work with ASHNHA on ideas for hospital clinical quality improvement learning session.

II. Commission members: E-mail questions to Deb for August meeting presenters on behavioral health, rural sanitation, and military/VA health system.

JUNE 19, 2014 DISCUSSION NOTES

PRICE & QUALITY TRANSPARENCY

Comments on HFMA Transparency Task Force Report

- Paper helpful and well written.
  - Helpful identification of the roles of the various stakeholders relative to different categories of patients (grouped by payer source)
  - Made the challenges more apparent

- Came away feeling as though we won't get a good product from following the recommendations
  - The paper's a really great start, but where's the impetus for change?
  - Too broad for driving legislation
  - Paper focused on price sensitivity and collaboration. "Price" sensitivity in Alaska isn't as important as "value" sensitivity. Alaskans are willing to pay a higher price for a good or service if they are getting good quality and local access at an affordable price.

General Comments on Transparency

- It's complicated —
  - There are so many people participating– hard to make it fair for everyone involved.
  - Gathering data from providers is complex – how do you verify they are telling the truth? About both price and quality.
  - Being able to provide data to plan members is a competitive issue for insurers – being able to provide consumer tools for transparency is something insurance carriers compete on.

- Considerations:
  - Quality measures must be included
  - Patient incentives must be aligned
    - Need to foster consumer (patient) engagement
    - Price sensitivity through high deductible health plans (HDHPs)
      - Research demonstrates that HDHPs combined with transparency are effective at reducing costs by up to 30% with no reduction in health outcomes
      - Marketplace is starting to drive this through ACA changes
        - Bronze and silver plans have high level of cost sharing
        - Cadillac Tax driving employers away from traditional comprehensive health plan models
  - Education is important
    - Patient/health plan members must be educated to ask questions BEFORE procedures, and understand what questions to ask and what the answers mean
      - HFMA has a new Consumer Guide for understanding healthcare prices
    - Provider staff must be educated re: patient communication
      - HFMA has patient financial communication best practices for providers
  - Patient relationship with their clinician is important
  - Design of local health care market and choice is important

- Conclusions:

- We all need to get on board and do this, but how do we do this? It's really hard work.
- Need to define the problem we're trying to solve: What's the goal? Need clear articulation of goal. Who will be able to solve the problem? Do the potential solutions work? And will they work on our scale? Will we see a return on our investment?
- One role for providers is to provide transparency of their prices and quality metrics for uninsured and out-of-network patients.
- Transparency initiatives will take a lot of collaboration between stakeholders — what are the drivers of collaboration? One potential role for the Commission is to identify the drivers of collaboration.
- We can/should take a more limited, selective approach, e.g. transparency for elective procedures, as a first step – don't need to do it all and get it perfect from the beginning.
- Use HFMA Task Force Report as a starting point – start with developing Principles & Guidelines

- Legislative Considerations – balancing:
  - Consumer protection – right of patient and referring physician to know the cost
  - How do you dove-tail consumer protection needs with industry concerns and preferred approach?

Hospital Discharge Database Update

The Commission received a status report on new Alaska Department of Health & Social Services (DHSS) regulations that implement their recommendation that the State mandate participation in the database.

- DHSS released draft regulations last fall based on the Commission's recommendation.
- A second draft, revised in response to public comment to include most health care facility types covered under Certificate of Need rules, was released in March.
- Public comment is closed and the final regulations are in legal review.
- The first provider training session was held Tuesday of this week (June 17) and another is scheduled for next Wednesday (June25).
- The program has been renamed the "Alaska Health Facilities Reporting Program."

Next Steps

- Articulate Problem and Goal Statements: Compile and review Commission Findings Statements approved in prior years relevant to Transparency Recommendations
- Include a learning session on Transparency on the Commission's draft 2015 agenda regarding:
  - What insurers are doing to support transparency for plan members
  - What employers are doing to support transparency for employees
  - What private sector vendor tools for transparency are being developed and adopted
  - What other states' transparency laws include, and how they are working
  - Opportunities for adapting insurer or private vendor tools for the uninsured/general public

REPORT ON 2014 LEGISLATIVE SESSION

The Commission reviewed a list of health-related bills introduced in the 28th Legislature (2013-2014), categorized by the Commission's eight Core Strategies (available on the Commission's website). Of particular note:

- SB 135 (Sen. Olson) extending the Health Care Commission's sunset date from July 1, 2014 to 2017 passed, and was signed into law by the Governor yesterday (June 18).

- SB 169 (Sen. Giessel) establishing an Alaska Immunization Program passed, and was also signed by the Governor yesterday.
- HB 141 and HB 316 modifying medical fee payment and schedules under the Workers' Compensation program passed.

Mike Monagle, Director of the Division of Workers' Compensation, described how the Workers' Comp bills aligned with Workers' Compensation Board recommendations for improving cost and quality of covered medical services. Outstanding Board recommendations that would require legislation to implement include limitations on controlled substances and repackaging of pharmaceuticals, and application of evidence-based medical guidelines.

PUBLIC COMMENT PERIOD

Verne Boerner, President and Chief Executive Officer of the Alaska Native Health Board, shared some highlights about Alaska's Tribal Health System, and noted their efforts to partner with the Department of Health & Social Services, and their interest in working with the Commission.

David D'Amato, from the Alaska Primary Care Association (APCA), testified on the Community Health Center System in Alaska. He updated the Commission on the status of APCA's Patient Centered Medical Home (PCMH) Project, funded by the legislature ($400,000) in 2011. He also noted plans for a Payment Reform Project associated with the next phase of the PCMH project. APCA is working closely with the Department of Health & Social Services on these initiatives, and using findings and recommendations from the Health Care Commission on PCMH and Payment Reform as a guide.

EMPLOYER HEALTH BENEFIT SURVEY RESULTS

<u>Employer Survey Result Presentation</u>

Highlights of results of the Commission's contracted survey conducted by the Institute for Social & Economic Research (ISER)/UAA in collaboration with the Alaska Department of Labor & Workforce Development were presented by Dr. Mouhcine Guettabi of ISER. A few highlights from the data presented (slides available on the Commission's website; final report to be released this summer):

- The percentage of Alaskan firms (of all sizes) offering health benefits to employees declined from 39% in 2006 to 34% in 2013.
- 29% of very small firms (<10 FTEs) offer employee health benefit, compared to 91% of large firms (>99 FTEs)
- 84% of full time employees in Alaska work in a firm that offers health insurance.
- The predominant reason for not offering health benefits cited by firms of all sizes (of those not offering benefits) was price and an inability to afford the expense.
- 19% of firms offer Health Reimbursement Accounts and 27% offer Health Flexible Spending Accounts to their full time employees.
- 6% of firms offer a salary bonus in lieu of health insurance to their full time employees; 4% contribute to a union health benefit trust on behalf of their employees; 1.8% directly purchase medical services, and 1.6% directly provide medical services for their employees.
- 50% of Alaskan firms think wellness programs are important or very important; but only 8% of firms have implemented a wellness program. Of those firms with a wellness program, 75% believe their

program is effective or somewhat effective (8% believe it's ineffective; the remainder don't know or didn't answer).

Commission Discussion

Initial Reaction and "Take-Away" Thoughts and Questions:

- The largest gap in Employer-Sponsored Insurance is among small employers – what do we do about that?
- Alaskans think wellness is important, but don't do it. Stunned by the gap in what Alaskan employers are doing related to wellness and the national data on employer wellness programs. Why is that gap so large?
- Impact of seasonality of economy and workforce; of population change.
- How will the baby boomer bubble in the workforce change the workforce demographic over time, and how will that impact the Employer-Sponsored Insurance coverage picture?
- Understanding benefit design at a deeper level is essential to understanding how employers and employer-sponsored insurance are impacting the health care market.
- We need to repeat the Employer Health Benefits Survey Study in 2 or 3 years to track how employer practices and prices in Alaska are changing.

Additional Questions the Commission has for Alaskan Employers:

- Are you moving away from more traditional, comprehensive plans to HDHPs (High Deductible Health Plans) and other new plan designs?
- Are there other alternative ways you are looking at providing medical care for employees? e.g., are you offering medical care directly to your employees?
- How are health care costs in Alaska impacting your non-health care –related business decisions? Ask both private sector employers, and public employers (State, Local/School Districts, Military)

Additional Questions for Researchers:

- What is the age demographic of Alaska's workforce?
- What is the impact of HDHPs (High Deductible Health Plans) on employee engagement?
- What is the impact of the Affordable Care Act's $2400 HRA (Health Reimbursement Account) limit (in IRS rules) on employer and employee engagement? Would a policy change at the federal level made to IRS HRA rule limitations increase small employer engagement?
- What is the tipping point for underinsurance? At what point are deductibles so high that they create a financial barrier to care?
- How and why does employee eligibility for insurance and actual enrollment vary — specifically, what are employees' reasons for not enrolling in employer-sponsored insurance? To what extent do alternative coverage options factor in? To what extent do cost and affordability factor in?
- What has research demonstrated about effectiveness and ROI (Return on Investment) of wellness programs?
    - It's important to distinguish between disease management, complex case management, and wellness programs when asking the ROI question.
    - There are targeted interventions that have been proven to make a difference (e.g., tobacco cessation), and others that don't necessarily turn a ROI but are "the right thing to do."
    - Premera uses Andrew Sykes with the firm HealthAtWork for wellness actuarial analyses and consultation. The Commission could consult with him on this question.

INSURANCE COVERAGE QUESTIONS

The Commission discussed the question – beyond what we have learned about employer-sponsored health insurance from the survey, what questions do we have about insurance coverage in general in Alaska?

- How do we define access? How does insurance status affect access to health care?
- What is the difference between insurance coverage and other forms of health benefits (e.g., Military, VA, Indian Health Services), and how is insurance coverage defined?
- What are the current sources of coverage for Alaskans, and what proportion of the population is covered by each?
- What are the demographics, especially by age, of the insured and uninsured populations?
- Is insurance as we know it today ever going to be able to meet the needs of the uninsured?
- How do insurance plans in Alaska compare to insurance plans in other states? How do benefit design, deductible and co-pay provisions compare?

INSURANCE REGULATION

The Commission very briefly addressed the question — Does Alaska insurance market regulation need to change, and what is the Commission's role in fostering the change? — Particularly pertaining to Commission findings regarding the 80th percentile payment requirement in regulation and the "Assignment of Benefit" law. The recent passage of a bill relating to air ambulance membership services was noted, as was potential interest in insurance rule changes to allow "concierge" medical practice.

Concern that consumer protections codified a decade or more ago in insurance rules and laws may be outdated and create barriers to innovation and free market function was noted. This conversation will continue with the Director of the Division of Insurance later in the year.

"PARKING LOT"

- Questions about insurance (not directly related to questions about coverage):
  - To what extent do lower negotiated rates between insurers and network providers factor in to the value of health insurance?
  - To what extent and how can insurance companies control hospital and physician prices in Alaska?

- What are public programs (TRICARE, Medicare, Tribal health system and Medicaid) doing to support and incentivize wellness?

- It's important to think of seniors as an economic force.
  - What is the impact of the senior population on Alaska's economy?
  - What are the demographic trends of Alaska's senior population, including permanent and seasonal intra and inter-state migration?
  - What are the health and support needs and need trends of Alaska's senior population?

JUNE 20, 2014 DISCUSSION NOTES

"TAKE-AWAYS" FROM YESTERDAY

- **Transparency:** Transparency will help the price/cost problem – price information available to all is important – we've got to get started on it, but it's complicated:
  - We need to restate and perhaps clarify our goal statements related to transparency
  - Can we craft a good law that will cover all the needs? No law is better than a bad law.
  - We need to balance simplicity with needs
  - We need to have good quality measures to accompany price data
    - Need to be able to capture quality data so it's comparable and fair
    - Simple quality parameters that don't take case severity into account will be skewed
  - Consumers need to be educated regarding how to request, understand and use price information
  - Consumer price/value sensitivity must accompany price and quality transparency efforts if transparency is going to make a difference. Consumer sensitivity is increasing as:
    - Employers move away from traditional more comprehensive insurance plans and towards High Deductible Health Plan designs; and,
    - Bronze and Silver plans sold on federal health insurance marketplace have high levels of cost-sharing
  - Need to understand how providers might game the system
  - All-Payer Claims Databases:
    - Have not seen dramatic successes from other states yet in terms of access and utilization by the public of transparency information from APCDs
    - Interest in and concern about health care costs is growing – people are starting to feel the pain – even if use of APCD by patients for transparency is low at first, it could grow over time.
    - APCD data is as important to referring physicians as it is to consumers/patients. And the trust relationship between primary care physician and patient is important.
    - Payers and insurers are starting to come together to share claims data with each other
    - Identify quality measures that can be tracked through claims data
    - Start with limited scope and phased approach, e.g., elective procedures, most utilized procedures, etc.
    - This is very complicated and it won't be possible for Commission to figure out the details — but we can lay out the principles.
    - Private sector and insurers are making a lot of progress. What if we ask Premera and Aetna to make their price and quality transparency tools available to Alaska's uninsured?
  - Getting through the legislative process is a challenge because legislators hear primarily from industry and not from citizens. The Commission can help educate the legislature on how the health care market works.
  - Collaboration between segments of the industry is important. The shifting market dynamics in part driven by the Affordable Care Act will drive collaboration. Is there a role for the Commission in facilitating collaboration?

- **Employer Survey:** The results from the employer survey are very helpful.
  - We need affordable health insurance premiums for small employers — the main drivers of higher insurance premiums in Alaska are higher hospital and physician prices (referenced Milliman Report).

- What are the effects of health care costs on the overall economy — on non-health care employers' business decisions?

- **Health Care Value:**
  - Two issues driving the Fairbanks economy wild right now are health care costs and energy costs. Military retirees bring retirement dollars to the community and if the cost burden gets too great they take their retirement dollars to another community. They'll stay even with higher prices because they prefer to stay for quality of life — until costs become unaffordable.
  - Choice is limited in smaller more remote communities — It's a value issue, not a price issue. When it comes to price sensitivity we're at a stress point because choice is limited in rural communities.
  - If we don't turn the curve on healthcare cost growth it'll be at 100% of GDP someday, and there's a lot of waste (30%). One form of waste is price that's extraordinarily high relative to the market.

FRAUD & ABUSE

Following-up on presentations on the Medicaid Integrity and Medicaid Fraud Control Programs at the March meeting, at this meeting the Commission had a presentation on Aetna's fraud control program, and then discussed ideas for potential fraud and abuse control improvements for the Medicaid program. The Commission also learned about new and expanding medical claims management tools and initiatives aimed at reducing waste.

MEDICAID FRAUD CONTROL UPDATE AND IMPROVEMENT IDEAS

Doug Jones, Medicaid Program Integrity ("MIP") Manager, and Andrew Peterson, Assistant Attorney General and Director of the Department of Law's Medicaid Fraud Control Unit (MFCU) updated the Commission and discussed issues and ideas for potential improvement of their programs.

Updates:

- Medicaid Fraud Control Unit (since Oct 2012): 93 criminal cases, 62 convictions, and provided the Medicaid Integrity Program with information to suspend 7 agencies. One large case involved investigating 53 individuals, with 35 convictions and $743,000 saved, bringing total savings from MFCU to $12 million for State of Alaska
- The federal Office of the Inspector General moved out of Alaska back when the Department of Law and DHSS were not collaborating because there wasn't enough work generated for them. The Department of Law and DHSS are actively collaborating now. Now, as soon as a search warrant is issued by MFCU, MIP is provided data to suspend providers before the criminal investigation is complete so the money path is cut off as early as possible, which is important since it is usually difficult to recover funds. But MIP is judicious about using the suspension process.
- MFCU/Department of Law has been hiring investigators with law enforcement experience, and relying on DHSS staff with health care expertise to help with audits. For example Division of Senior and Disability Services/DHSS Quality Assurance staff have been working very closely with MFCU staff.
- MFCU is also working very closely with OIG, and OIG is now looking at reestablishing an office up here because they have a workload here again. For now the U.S. Attorney from N. Dakota is going to start working part-time on Alaska cases.

- OIG has provided lots of technical support; The Immigration & Naturalization Service has helped provide information on out-of-country travel of providers billing for Alaska services
- One side benefit of the increased prosecutions is that judges are starting to understand health care fraud cases better.
- Recovery Audit Contractor (RAC) Audits: New Medicaid RAC program required under the Affordable Care Act – Alaska's Medicaid RAC contractor recently "quit" because not enough income generated in Alaska (due to audit focus on hospital DRG payments and Alaska's payment structure is primarily fee-for-service)
    - Then who is auditing hospital charges?
        - Medicaid rate review uses facility Medicare cost report to set a per diem rate based on the audit conducted in rate-setting process
        - Myers & Stauffer audits for other third party payment, overpayment of approved rate, and proof that patient was in the hospital for the dates charged.
        - The Utilization Review Contractor audits for medical necessity
        - For in-patient services, Prior Authorization and Utilization Review, not fraud audits, are going to catch the problems in Alaska. Since we're a small state and have few hospitals, fraud is a lot less likely among hospitals.

Improvement Ideas:

- Enroll rendering providers (not just agencies), and support DHSS to make the regulatory changes and with capacity to do the work.
- State audits performed by Myers & Stauffer under AS 7.05.200: Repurpose some or all of the discretionary audits and target the provider types that pose the greatest risk of overpayment.
- Reduce cycle time, from audit notification through final report issuance, and improve communication with providers (e.g., provide an on-line dashboard noting status of each audit/investigation).
- Strengthen collaboration between the Medicaid Fraud Control Unit, Medicaid Integrity Program, Division of Health Care Services, and federal fraud investigation and control programs.
- Fraudulent providers are exploiting vulnerabilities in the system.
    - Recipients have no "skin in the game"; and also don't receive an EOB (Explanation of Benefits) statement unlike a patient on a private insurance plan, so the Medicaid patient can't see if a provider is billing for services the patient did not receive.
    - Lack of enrollment of some provider types doesn't allow for identifying providers caught in fraudulent behavior under one provider type for which they are enrolled, who continue to bill for services under another provider type for which they are not enrolled.
- Myers & Stauffer audits don't generally identify criminal activity, but one recently identified fraud case will result in $1 million savings annually for the State, so these audits conducted under the state law are turning a benefit.
- One legislative fix would be to establish mechanisms for capturing funds through recovery, e.g., bonding and/or strengthening the state seizure law.
- Recovery Audit Contractor (RAC) Audits:
    - Process presumes guilt, and since focus is on in-patient DRGs and Alaska doesn't use DRGs, should consider request of the federal government to waive Affordable Care Act requirement to have a Medicaid RAC program.

MEDICAID CLAIMS MANAGEMENT

Dr. Lydia Bartholomew, Senior Medical Director, West Region Patient Management for Aetna, and Margaret Brody, Director Division of Health Care Services, shared examples of claims management tools and initiatives in use in their programs. Of note, Medicaid initiatives beginning or expanding in order to reduce waste in the program include:

- Expanding Prior Authorization requirements for medical necessity
- Pre-payment review for providers who have billed for services inappropriately (when fraud is not involved Medicaid provides education and 1-on-1 intervention to help providers learn how to bill properly)
- SURS (Service Utilization Reviews) – Identifies providers who are outliers from everyone else, e.g., is a particular provider billing for tobacco cessation for every single patient (including 2 year olds)? "Outliers" are put in a queue to be investigated. The current process is a burden for providers because they are asked to provide entire patient history, so the Division of Health Care Service (DHCS) is streamlining the process and targeting information gathering to outlying procedure(s) to lessen burden and shorten time it takes.
- New "SuperUtilizers" pilot program will address over-utilizers of emergency room services in Anchorage and MatSu. Beneficiaries who have used the emergency room four or more times in the past year are being mailed a letter today to ask for volunteers to participate in program. May be targeting close to 5,000 Medicaid beneficiaries. Four providers responded to the RFP for care coordination/management services for this population. Be on the lookout in September for a national article being published on the data analytics the Division of Health Care Services used to identify the target population.
- Another new initiative is identifying beneficiaries found to be travelling on Medicaid funds without attending a medical appointment. These folks will be receiving letters requesting they refund the State travel funds, and the individuals who arranged and/or approved the travel will also be investigated. PFDs will be garnished if funds are not repaid.
- The Division will also begin investigating beneficiaries who pay cash for prescriptions.
- An RFP is going out soon to pilot test electronic verification of PCA (personal care assistant) services. PCAs participating in the pilot will have to check in and check out of service recipients' homes electronically, and that data will be matched against Medicaid claims.

COMMISSION DISCUSSION – PRELIMINARY FRAUD RECOMMENDATIONS

- Enrollment of all rendering Medicaid providers by DHSS is a good idea
  - This can be accomplished through a regulatory change
  - DHSS will need the resources to manage it
- Statutory changes needed:
  - Require bonding of Medicaid providers and strengthen forfeiture/seizure laws to enhance recovery of funds
  - Prescription Drug Database:
    - Remove statutory barriers to DHSS and Department of Law access
    - Expand to a more robust program (such as WA State's):
      - Support upgrade of the database to real-time functionality to catch/prevent "doctor-shopping"
      - Ensure financial support to continue the program
  - Identify statutory barriers to collaboration between Department of Law and providers (proactive education)

- The Medicaid RAC Audit contractor leaving is a good thing – DHSS should seek a waiver from the federal government so the program does not have to be continued.
- More checks and balances are needed for the home and community-based service provider workforce – they serve an important need, but there is risk to sending workers into the homes of vulnerable individuals unsupervised. Identify the role of technology in helping with background checks and also in strengthening documentation of services provided.

JEFF'S PARTING THOUGHTS

This was Jeff Davis' last meeting after serving on the Commission in the health insurance industry representative seat since its inception under the Governor's Administrative Order (2009). Jeff was asked to share his thoughts on two questions: 1) What could be done to improve the insurance market in Alaska? And, 2) What do you believe the ideal health system for Alaska would look like? His answers:

1) There are structural problems in Alaska's private insurance market. Though it covers a relatively small proportion of insured Alaskans, the private insurance market sets the bar and drives prices for other payers in Alaska. Structural problems include:
   - The 80th percentile payment regulation, which was originally designed to protect consumers, but Alaska's health care market has grown up since then. One option for revision without discarding the provision entirely would be to establish a network adequacy standard and exempt carriers with sufficient networks.
   - The "Assignment of Benefit" law, which takes away a carrier negotiating tool/lever that can be used to control costs.
   - Anti-HMO/managed care language sprinkled through-out Alaska insurance law interferes with payment reform innovation and creates barriers to alignment of incentives between providers, payers and patients.

2) The ideal health care system for Alaska would eliminate waste and improve quality. It would:
   - Be physician driven, physician governed
   - Be centered around primary care
   - Give primary care physicians the resources they need to reengineer patient care at the site of care:
     - Money to do the extra care coordination/management work, plus
     - Information needed to do the work
   - Support Alaskans to take personal responsibility for their health (75% of health care costs are due to chronic conditions which are largely preventable)

He noted that the presentation made to the Commission by Dr. Dobson on North Carolina's Community Care program in June 2012 was the impetuous for a new initiative under development by Premera and a group of local private practice physicians to create a business model based on the characteristics noted above. Members not present for that 2012 presentation asked for a link to the webinar recording of that session.

UPDATES

- Senator Donny Olson, former ex-officio Commission member, joined the group for the update by Commissioner Streur. Sen. Olson was acknowledged and thanked for his sponsorship of the bill to extend the Health Care Commission.

- Commissioner Streur (DHSS) met with the Commission and discussed the status of the Medicaid Reform Effort. He noted that the analysis of services available and lacking for the "gap" population (those below 100% federal poverty level who don't qualify for Medicaid and don't qualify for a federal insurance subsidy) was released by his office a couple weeks ago. They identified between 10,000 and 12,000 Alaskans in the "gap" who don't have insurance and who don't otherwise qualify for other health care benefits through the Tribal Health System, Department of Defense, Military, etc.). There are still unanswered questions about this population, e.g., what are their health needs, how often they use emergency rooms, etc.

  The Commissioner also discussed the status of the Alaska Medicaid Reform Advisory Group:
  - Nine members appointed by the Governor charged to develop recommendations for improving the current Medicaid system (not to make a recommendation regarding whether the State should expand the Medicaid program)
  - Began meeting in April and meeting monthly
  - Will produce a report detailing Medicaid Reform ideas for the Governor in November

  Budget challenges and cost containment have been the most significant issues addressed so far. More specifically they have so far discussed optional Medicaid services, reimbursement rates, bundled payments, and tribal partnerships. In upcoming meetings they will look at other States' reform efforts, the status of Medicaid managed care, and will review recommendations from the last Alaska Medicaid reform group and evaluate status of implementation and outcomes from those prior recommendations. Waste in the system was mentioned, and opportunities for containing cost by improving care and cutting down on costly ineffective services was noted. The group's very short timeline was acknowledged. Their report to the Governor will most likely be the first step in an ongoing effort.

- Healthy Alaskans 2020 leaders, Lisa Aquino of the State Division of Public Health and Emily Read of the Alaska Native Tribal Health Consortium, presented an update on the initiative, which is key to implementing the Commission's "Focus on Prevention" Core Strategy:
  - They have identified the 25 Leading Health Indicators for Alaska for the decade (handout provided), and are now in the statewide strategy development phase.
  - An assessment of Alaska's public health system capacity was recently conducted, and the report will be released in September.
  - A significant challenge going forward is the loss of the federal grant supporting the initiative.
  - Commission members asked:
    - For data on Leading Health Indicator baseline and trends (Deb will send link to the Healthy Alaskans LHI data report report); and
    - About the level of funding required to keep the initiative going (presenters will follow-up).

MEETING WRAP-UP

PLANS FOR FUTURE 2014 MEETINGS

- Transparency:
  - Do not plan a stakeholder session on Transparency for the fall — it's premature at this point.
  - Include more learning about the status of transparency efforts on future (2015) agendas

- Ideas for October Clinical Quality Improvement Learning Session:
  - Quality is good – but need to focus on what works to improve outcomes, eliminate waste, and reduce costs.
  - Look at hospital/health system quality improvement initiatives that have demonstrated success, include how they connect to clinics/primary care:
    - Virginia Mason's experience with Toyota Total Quality Management
    - Southcentral Foundation's clinical quality improvement initiative (ask Dr. Tierney)
    - Institute for Healthcare Improvement
    - Work with ASHNHA to identify Alaska hospital initiatives, e.g., Alaska Regional/HCA examples noted by Julie

- Questions for August meeting presenters:
  - Ran out of time to discuss, so members were asked to submit questions for August meeting presenters on behavioral health, rural sanitation, and Alaska's military/VA health systems to Deb over e-mail.

MEETING EVALUATION

- What the group liked about this meeting:
  - Discussions were substantive
  - Session on fraud and abuse was interesting – good ideas for improvement presented
  - Alaskan employer survey results were very interesting
  - Jeff Davis' parting thoughts on how to improve health care in Alaska were good.
  - Lunch

- Wishes for future meetings:
  - 2-day meetings are too long – go back to 1.5 day meetings
  - More focused questions and direction in facilitation
  - Alaska-focused presentations
  - Ice cream